

The California Commission on Health and Safety and Workers' Compensation



Preliminary DRAFT

CHSWC Background Paper on Twenty-Four Hour Care

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Introduction

Employers in California experience higher costs for workers' compensation claim medical care than employers in most other states, and California ranks highest in workers' compensation claim premium rates.¹ Workers' compensation medical expenditures skyrocketed from \$2.6 billion to \$5.3 billion between 1995 and 2002 and it is estimated that in 2004, medical payments will account for two-thirds of all workers' compensation benefit costs.

Several reports have pointed to the high utilization of specific kinds of medical services in California's workers' compensation system as a major reason for this differential. According to the Workers' Compensation Research Institute (WCRI), the average number of medical visits per workers' compensation claim in California is over 70 percent greater than other states.² The higher utilization is primarily due to higher rates of particular types of services, including physical medicine, psychological therapy, and chiropractic care.

Suggestions have been made to more closely coordinate or combine workers' compensation medical care with the general medical care provided to patients by group health insurers, in order to reduce overall administrative costs and derive other efficiencies in care. In the early and mid-1990's, several states, including California have examined the feasibility of these suggestions under the heading of 24-Hour Coverage Pilots. A survey of various states' experiences is examined below.

Definition of Twenty-Four Hour Coverage

According to Burton (1997), "twenty-four hour coverage describes various efforts to reduce or eliminate the distinctions between benefits and services provided to disabled workers for work-related injuries and diseases, and benefits and services provided for non-work-related injuries."³ (See attached article) These programs allow employees to seek treatment for occupational injuries from their primary care physician or from an occupational health care specialist affiliated with their regular non-occupational health care provider's network.⁴

¹ WCIRB *Annual Reports*, San Francisco: WCIRB, 1998-2003.

² WCRI. Eccleston, S., et al. *The Anatomy of Workers' Compensation Medical Costs and Utilization*. Cambridge, MA: Worker's Compensation Research Institute, 2003.

³ Burton, John F., Jr. *Workers' Compensation, Twenty-four Hour Coverage, and Managed Care*. National Academy of Social Insurance, 1997.

⁴ Kominski, Gerald F., et al. *Evaluation of California's 24-Hour Coverage Demonstrations: Final Report submitted to The Robert Wood Johnson Foundation and the California Department of Industrial Relations*. UCLA Center for Health Policy Research. 2001.

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The above definition encompasses many variations and ranges of 24-hour coverage. The range of definitions includes:⁵

- A seamless health and disability system, providing medical care and indemnity benefits to injured workers whatever the cause of injury and illness. This integrated system would include a common provider network and combined disability management programs.
- A coordinated system of health care delivery, whereby a person receives all medical care for injuries and illnesses from a single health care provider.
- A system where claims from various benefit systems are handled by the same party or at the same location.

Twenty Four Hour Coverage: Benefits and Problems of Implementation

Benefits

Some of the benefits of 24-hour coverage which are voiced by advocates could potentially include:

- Streamlined and more cost-effective administration through the eliminating of duplicative services which result from parallel administrative systems.
- Reduction in costs shifting between insurance systems which could occur from similar wage benefit plans.
- Improved communication among health care providers.

Implementation Barriers to 24-Hour Coverage

Interviews with different states, as well as various reference sources, reveal that there can exist several implementation barriers to 24-hour coverage.

- Employee Retirement Income Security Act (ERISA) and interaction with state-administered workers' compensation law.
ERISA sets federal standards for employer-provided pension plans and welfare plans that include health insurance and other types of benefits. States are permitted under ERISA to regulate workers' compensation programs, but may not regulate other programs encompassed by ERISA. Thus, a state could not obligate an employer to provide medical benefits for non-occupational injuries and illnesses. State laws establishing pilots have made the 24-hour care programs voluntary to avoid the ERISA preemption.⁶ However,

⁵ California Division of Workers' Compensation, Department of Industrial Relations. *Interim Report to the Legislature: 24-Hour Pilot Programs under Labor Code Section 4612*. 1997.
Available at: <http://www.dir.ca.gov/dwc/24intrpt.pdf>

⁶ Burton, John F., Jr. *Workers' Compensation, Twenty-four Hour Coverage, and Managed Care*. National Academy of Social Insurance, 1997.

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according to Oklahoma, Hawaii, and Maine, the ERISA issue was one of the main barriers to implementation of 24-hour coverage. In Maine, a lawsuit ensued on this issue.⁷

- Differences in availability, eligibility and due process between occupational and non-occupational disability systems. Some of the differences are the following:
 - Workers' compensation provides medical benefits for the time period of the claim, and these benefits are generally unlimited. General health insurance pays for services that are received during the policy period with no obligation for subsequent services.
 - General health insurance usually requires the individual to pay co-payments and deductibles while workers' compensation does not.
 - Under workers' compensation, employees have extensive due process rights regarding modification and termination of benefits with guarantees of access to courts, and timeliness of decisions.⁸

The above barrier deterred some states from putting in place or making operational 24-hour pilots. For example, the State of Wisconsin's Advisory Council deliberated the issue of 24-hour care coverage, but did not recommend it due to both insurance carrier and labor opposition. Insurance carriers opposed it due to the fear that they would not be able to manage two structurally different systems.⁹ In Oklahoma, the reasons the pilot did not become operational was due to labor opposition to co-payments that employees would have had to pay in a coordinated system and employers' uncertainty about the risks of such a system. In particular, employers believed that the implementation costs of an integrated system would make it unprofitable for them to participate.¹⁰

Aside from the above reasons, one of the main reasons why the pilots did not become operational in many states was due to low employer interest in 24-hour care. The lack of employer interest stemmed mainly from the stabilization and reductions in premium rates that occurred in the mid-1990's.¹¹

⁷ Conversation with Bob Wake, Staff Attorney, Maine Workers' Compensation Board.

⁸ Dembe, Allard E., et al. Improving Workers' Compensation Medical Care: A National Challenge. Center for Health Policy and Research. MA. 2003.

⁹ Conversation with Jim O'Malley, Director of Bureau of Legal Services, Wisconsin Workers' Compensation Division.

¹⁰ Conversation with Kevin Nelson, General Counsel, Oklahoma Compsource.

¹¹ Conversations with Byrl Thompson, Insurance Policy Specialist at Kentucky Department of Insurance and Bob Wake at Maine's Bureau of Insurance.

Various States' Experiences with 24-Hour Care Pilots

Overview

The increasing cost of medical care in workers' compensation in the 1980's and early 1990's gave impetus to several states' efforts to pilot 24-hour care programs. Ten states passed Legislation in the early and mid-1990's authorizing 24-hour pilot programs. According to state interviews and a National Association Insurance Commission report, these states are: California, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Oklahoma, and Oregon¹² (see attachment A). Five other states, Hawaii, Iowa, Montana, North Carolina, and Washington, have examined and held discussion on issues of 24-hour care.¹³

The statutes authorized pilots which would allow employers to offer employees an integrated health care plan covering both general health care needs and medical treatment for work-related injuries and illnesses with prior approval from the state agency. Although several states authorized pilots, only Oregon's and California's pilots became operational due mostly to the barriers mentioned above.

Some of the key pilots and efforts by states on 24-hour coverage are summarized below:

California

In 1993, amended legislation mandated the Division of Workers' Compensation (DWC) to conduct a comprehensive evaluation of the 24-hour health care pilot, including an assessment of medical, indemnity and administrative costs, enrollment patterns, work and litigation outcomes, and employee satisfaction. The projects were piloted in San Diego, Los Angeles, Sacramento and Santa Clara Counties. The majority of participating employers and employees were signed up with Kaiser in Northern and Southern California. Kaiser's 24-hour care program was called Kaiser on the Job.

Pilot Program

The pilot program was intended to determine whether or not 24-hour care could reduce costs (through administrative efficiencies and reduced cost-shifting) and improve quality of care (through better access and continuity). In the 24-hour pilot, employers could contract with a state-licensed HMO to be the exclusive provider of medical treatment for occupational and non-occupational injuries and illnesses for enrolled employees. Employers choosing to participate in pilot programs were required to make group health coverage available to employees and their

¹² National Association of Insurance Commissioners. *NAIC 24-Hour Coverage Statutes*. 24 Hour Coverage Symposium. NAIC. 1995.

¹³ National Association of Insurance Commissioners. *A Progress Report on the Implementation of 24-Hour Coverage*. NAIC. 1999.

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dependents. Employees who chose to enroll in the 24-hour program would receive all medical care for work injury from the 24-hour provider for one year after the date of injury.

Results of the Pilot

- Pilot firms had lower costs prior to joining the 24-hour care coverage pilot programs, particularly among the Kaiser fee-for-service claims.
- For temporary disability (TD) and permanent disability (PD) claims, there was no statistical difference in medical expenditures between the 24-hour care pilot groups and the fee-for-service groups.
- For medical-only claims, the Kaiser on-the-job claims were 20 to 34 percent more expensive than Kaiser fee-for-service claims within pilot firms.
- This study demonstrated no significant differences in patient satisfaction with care or emotional or functional outcomes in injured workers receiving usual care versus 24-hour care.

California State Compensation Insurance Fund/Kaiser Alliance

The State Compensation Insurance Fund (SCIF)/Kaiser Permanente Alliance program is a coordinated claims and medical case management program. The Alliance is designed to speed and enhance communication and cooperation between the employer, the injured worker, the treating physician and the claims representative. By overcoming barriers to return to work, the Alliance seeks to improve patient satisfaction and medical treatment outcomes, while reducing employer costs.

The Alliance is not an HCO program, thereby easing employer entry and convenience to participate, while reducing administrative costs. The Alliance was created in 1995 by Kaiser Permanente and SCIF. Alliance savings and results have been independently and annually reviewed by outside consultants. As measured by premium volume or enrolled employers, SCIF reports that the Alliance is the most successful Health Care Organization/workers' compensation carrier coordinated-care program in the United States.

The following information is from the Executive Summary of the "State Fund/ Kaiser Permanente Alliance Evaluation: Phase 4", published in March 2003:

"Phase 4 of the iterative State Compensation Insurance Fund/Kaiser Permanente Alliance Evaluation Project analyzed of 27,514 Alliance policy claims with Kaiser involvement, 18,356 Alliance policy claims without Kaiser involvement and 266,570 control-group claims with dates of injury between 1996 through 2000.

The analyses of Alliance claims (with treatments provided by both Kaiser and non-Kaiser providers) showed the following unadjusted results across all injury years compared with non-Alliance control group claims:

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- Average medical paid costs for Alliance Kaiser and Alliance Kaiser were significantly lower, by 41.4 percent and 13.5 percent, across all injury years compared with control-group claims.
- Average total TD paid per claim for Alliance Kaiser claims compared with control groups was 11.2 percent lower. For Alliance non-Kaiser claims, the average total TD was 10.8 percent lower than control-group claims.
- Average total PD paid amounts for Alliance Kaiser and Alliance Non-Kaiser claims were 32.8 percent and 25.5 percent lower, respectively, than the control groups.
- Alliance Kaiser and Alliance non-Kaiser had 33.1 percent and 10.9 percent lower attorney involvement than control-group claims.

Results from Comparisons of Kaiser Involvement Groups

- In almost 9 out of 10 Alliance claims, when Kaiser was given the opportunity to treat an injured worker, Kaiser maintained medical control over the life of the claim.
- The lowest average paid amounts for both Alliance and control-group claims occurred among the claims with Kaiser as the predominant provider.

The analyses of Alliance claims (with treatments provided by both Kaiser and non-Kaiser providers) showed the following case mix adjusted results across all injury years compared with non-Alliance control-group claims:

- Average claim paid for claims with Kaiser as the predominant provider was 50.9 percent lower for Alliance claims than for control-group claims.
- Average claim paid for Alliance claims with Kaiser as the predominant provider was 83 percent, 89 percent, and 67 percent less than that for Alliance claims with Kaiser in the first 30 days, Kaiser after the first 30 days, and no Kaiser, respectively.

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Oregon¹⁴

Oregon conducted 24-hour care pilots with the enactment of the appropriate statute in August of 1993. Four pilot plans became operational in 1996. These were:

WORKER'S COMP. PARTNER HEALTH INSURANCE PARTNER	ENROLLED EMPLOYERS	ENROLLED EMPLOYEES
SAIF Corporation HMO Oregon (Blue Cross)	9	2,235
EBI Companies Providence Health Plan	1	80
EBI Companies PacificSource Health Plans	2	381
Self-Insured Employers Kaiser Permanente	2	928

The low enrollment was the project's principal problem. The enrollment target when the project began was 10,000 to 20,000 employees, but only 3,624 employees were ultimately enrolled. According to the Robert Wood Johnson Grant Report on the project, the low employer involvement was due to political and economic changes during the grant. Some of these changes included:¹⁵

- The collapse of the Clintons' health care reform drive at the national level led to decrease in much of the pressure on state legislatures to initiate schemes for integrated health coverage plans.
- The sunset date of Oregon's employer mandate provision of January 2, 1996.
- An unprecedented reduction and subsequent stabilization in workers' compensation rates and premiums in Oregon between 1991 and 1996.

According to the Robert Wood Johnson Grant Report on the project, the primary obstacles to full integration were:

- Claims handling, since workers' compensation involves not only medical treatment but also payment of disability benefits.
- Financing, since workers' compensation and group health coverage are priced very differently, and because employees partially pay for group health medical services through co-pays and deductibles.

¹⁴ Robert Wood Johnson Foundation. *Grant Results Report: Pilot Project to Combine Workers' Compensation and Health Insurance*. 1997. Available at: <http://www.rwjf.com/reports/grr/020229s.htm>

¹⁵ Joseph, Robert. *24-Hour Coverage: The Oregon Pilot*. FORC Quarterly Journal of Insurance Law and Regulation. December 7, 1997 Vol. IX, Edition IV. Available at: <http://www.forc.org/journal/winter97/article1.htm> and Conversation with Mike Manley, Research Coordinator, Information Management Division, Oregon Department of Consumer & Business Services.

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Key Findings of the Oregon Pilot

- Coordinating the medical care for workers' compensation and health insurance is feasible. Barriers that previously prevented the coordination of medical care proved to be conceptual not practical. Due to political and economic changes during the grant, there was not a viable interest in integrating medical care for group health insurance and workers' compensation into a single insurance policy.
- There were also aspects that the pilots felt could be integrated: establishing a single medical provider reimbursement schedule and lost-time duration management, or managing the duration of lost-time injuries.

Florida¹⁶

Florida's pilot program became effective in 1994. Statute 440.135 authorized pilot programs under which participating employers would provide a 24-hour health insurance policy to their employees under a single insurance policy or self-insured plan. (See Attachment B) According to the legislation, "the policy or plan had to provide a level of health insurance benefits which met the criteria established by the Department of Insurance but which provided medical benefits for at least occupational injuries and illnesses comparable to those required" by this Florida Workers' Compensation Statute.

Minnesota¹⁷

The 1995 amended legislation required the Commissioners of Health, Commerce, and Labor and Industry to develop a pilot 24-hour coverage plan, coordinating the medical benefits of workers' compensation with health care benefits to be offered by an integrated service network, health maintenance organization, or an insurer or self-insured employer. According to the Minnesota Department of Labor and Industries, the pilots were not implemented due to lack of employer interest. The interest in 24-hour care waned in the mid-1990's because workers' compensation costs were low at the time.

Although Minnesota did not implement a full 24-hour care program, it did pilot an integrated benefits program with funding by the Robert Wood Johnson Foundation. This program was called the "The Minnesota Health Partnership" and was a variation on the 24-hour care product.

¹⁶ Bobbi Markowitz, Research Coordinator, Florida Division of Workers' Compensation and Florida Statutes.

¹⁷ Grail, Lohman, Calasanz, Christianson, Cortez, Gorman, Parker, Radosevich, Westman. "The Minnesota Health Partnership: Coordinated Health Care and Disability Prevention: The Implementation of an Integrated Benefits and Medical Care Model." Journal of Occupational Rehabilitation 12, no. 1 (2002): 43-54.

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The Minnesota Health Partnership, a diverse group representing employers, health care provider organizations, labor, insurers, and state government agencies, developed a coordinated health care delivery model which integrated claims management and had the following characteristics:

- Insurance and regulatory arrangements of workers' compensation and group health were kept the same, and each system continued to pay out benefits as required.
- Management of medical costs and indemnity benefits were combined into a single claims-processing operation with complete sharing of information and common administration.
- Case-management services and return-to-work services were provided to all injured employees regardless of whether the injury is work-related or not.

*Key Findings or Accomplishments*¹⁸

This model, Coordinated Health Care and Disability Prevention (CHCDP), was implemented in many clinics in the Minneapolis/St Paul area. It increased the awareness of the potential benefits of disability prevention and accelerated the movement of the Twin Cities marketplace toward integrated/coordinated health care.

Evaluation of the model's impact on patients, participating providers and employers revealed the following findings:

Patients

- The joint effects of disability prevention and a strong patient-provider relationship were associated with decreased risks of poor physical health; decreased restricted activity days; and overall satisfaction with their primary care provider.
- Results suggest that primary care providers with strong patient-provider relationships can successfully add disability prevention to their practice without a decrease in patient satisfaction.
- Patients who reported receiving Activity Plans rated their provider higher in relation to time spent with the provider, provider skills, and, overall clinic satisfaction.

Providers

- Providers showed a high level of agreement about the importance of disability prevention principles (i.e., discussing appropriate activity is useful for patients, prompt return to activity prevents de-conditioning, and early return to work helps prevent disability); however, the actual implementation of these practices was neither widespread nor uniform. In particular, the use of a generic written activity plan was not widely accepted.

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- Test clinic providers reported greater confidence in their disability prevention skills. This suggests that ongoing discussion and educational efforts relating to disability prevention strategies may continue to focus attention on the role of disability prevention strategies within primary care practice.

Employers

- Pilot employers reported having more formal stand-alone policies for non-work-related conditions and reported greater success in accommodating non-work-related conditions than controls.
- Seventy-eight percent of test and control front-line supervisors felt that an activity plan could aid an employee's early return to work, and 67 percent felt it was very useful. As with the provider survey, there were areas of agreement among all employers, which suggests a common culture related to disability-prevention principles. These include:
 - Agreement in the benefits of providing accommodations for both work-related and non-work-related conditions.
 - A high comfort level for discussing employee work restrictions for both work-related and non-work-related conditions.
 - The potential utility of an activity plan.
- The organizational analysis, evaluating the impact of the model on employers, healthcare organizations, and health plans concluded the following main points regarding the implementation of the CHCDP model that could be used in understanding and to help identify strategies to transfer the model to other communities:
 - Changing physician behavior is inherently difficult.
 - The time-limited period for the intervention discouraged fundamental behavioral change.
 - The small scale of the intervention made system changes impractical.
 - Community-based coalitions for health care reform are inherently fragile.
 - Competing initiatives/research studies created pressures that competed against successful implementation.
 - Although there was evidence of CHCDP's clinical implementation, ultimately, the experience underscored how difficult it is to carry out meaningful research projects in "real world" practice settings when the projects require physicians to change their interactions with patients and where there is not immediate positive feedback to physicians in the form of improved patient health outcomes, satisfaction, or reimbursement.
 - Overall, the results suggest the importance of disability prevention principles as reported from providers, employers, and patients. Both provider and employer practices of implementing different principles may be varied, but the agreement of value is present. Most significantly perhaps, is that patients reported better mental and physical outcomes, along with greater satisfaction when disability-prevention

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practices were used in the provider setting within the context of a strong patient-provider relationship.

A report was submitted to the Legislature in 1996 on the Minnesota Health Partnership. However, the Legislature never acted on the findings of the report.

According to Brian Zaidman at the Minnesota Department of Labor and Industries, there was insufficient funding for the project to move forward.¹⁹

Maine

Maine enacted legislation in 1991 which authorized it to develop 24-hour pilot projects. In 1995, the Main Bureau of Insurance received a grant from the Robert Wood Johnson Foundation for the implementation and evaluation of the pilot projects. The project involved the development of 24-hour coverage pilot projects, including the establishment of a planning task force, hiring of a consultant to expedite implementation and participation of vendors and purchasers, and setting up an evaluation program by researchers from the University of Southern Maine.

Findings

According to interviews with the Maine Department of Insurance, the two primary reasons why the project never became operational were that²⁰:

1. ERISA issues made it difficult to determine whether the state or the federal government would have jurisdiction over an integrated occupational and non-occupational plan. Some believed that combining a self-insured health plan (state regulation or oversight of self-insured health plan is preempted by ERISA) with workers' compensation means that the state will lose its jurisdiction over ERISA.
2. A decrease in Maine's insurance rates over the course of the project leading to improvements in costs made the 24-hour coverage idea less interesting to employers and carriers.

Other findings and lessons learned from the road blocks of the project included:^{21,22}

- An integrated product does not appear to reduce all the administrative burden for providers and carriers, as occupational injuries are still required to be filed with the state

¹⁹ Conversation with Tammy Lohmann, Chief Workers' Compensation Analyst at the Minnesota Department of Commerce, and Brian Zaidman, Research Coordinator, Minnesota Department of Labor and Industries.

²⁰ Interview with Richard Johnson, Property and Casualty Actuary at the Maine Bureau of Insurance and Robert Wake, Attorney, Maine Bureau of Insurance.

²¹ Robert Wood Johnson Workers' Compensation Health Initiative. *Maine 24-Hour Pilot Project*. Available at: <http://www.umassmed.edu/workerscomp/grants/grant8.cfm>

²² State of Maine, Department of Professional and Financial Regulation. *Maine's 24-Hour Bureau of Insurance Coverage Pilot*. Complete Grant Report to the Robert Wood Johnson Foundation. 1997.

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and the providers and carriers would still be subject to the administrative rules and regulations of both the health and the workers' compensation regulators.

- Over 30 bills were introduced in the 1997 Legislative session that would have overturned the reforms which brought in 24-hour pilots. These proposals made most parties that could have entered with a viable 24-hour product reluctant to do so in an uncertain market.
- The challenges of mixing an occurrence-based coverage (workers' compensation) with a policy-year coverage (health) and determining the proper pricing of the product requires special expertise and presented unique problems for the industry.
- Training traditional health providers to the responsibilities and obligations of the workers' compensation system (disability evaluations and communication with the employer, etc.) requires some expenses for traditional health carriers thinking about providing integrated products.
- Coordinating fee-for-service and capitated provider-payment plans creates more administration and required knowledge on the part of billing and accounting personnel.

States with 24-Hour Coverage Pilot Statutes

State	Statute
California	4612
Florida	440.135
Georgia	34-9-122.1
Kentucky	216.2960
Louisiana	22.21; 22.22; 22.23
Maine	Title 39 Section 403 (2)
Massachusetts	152 Section 10 (C)
Minnesota	Chapter 625. Article 5 Section 7; Minnesota Law of 1994
Oklahoma	85 Section 14.1
Oregon	Chapter 758 Oregon Laws 1993

Source: NAIC (1995), NAIC (1999), States' Statutes

Notes: The information in the table above was published in 1995. The following are updates to the table.²³

- California: Repealed statutes in 2001.
- Minnesota: Legislation amended in 1995.
- Florida: Legislation is not in 2003 Statute.
- Oregon: Sunset of Legislation in 1996.
- Massachusetts: 24-hour care pilots are in the statute relating to collective bargaining agreements.

²³ Interviews with states; NAIC (1999)

Attachment B

Various states 24-Hour Care Pilot Statutes and Rules

California

CALIFORNIA LABOR CODE SECTION 4612

(a) A pilot project is hereby authorized, for duration of up to 36 months, under regulations to be developed and implemented by the administrative director. The purpose of the pilot project is to authorize an employer participating in the pilot project to contract with a licensed health care service plan to be the exclusive provider of medical, surgical, and hospital treatment for occupational and non-occupational injuries and illnesses incurred by its employees. The health care service plan shall provide all occupational-related medical treatment coverage required by this division without any payment by the employee of deductibles, co-payments, or any share of the premium. Employers participating in the pilot project shall make available health plan coverage for their employees' dependents for the treatment of non-industrial injuries and illnesses. Nothing herein shall require an employer to pay for that dependent coverage. An employer participating in the pilot project shall offer its employees a choice between the exclusive provider of care option and a traditional health benefits plan which allows employees to obtain workers' compensation treatment from a traditional workers' compensation provider. In the case of a pilot project established by a multi-employer, collectively bargained employee welfare benefit plan, or by a recognized exclusive bargaining agent for state employees that sponsors an employee welfare benefit plan for the benefit of employees, this choice may be exercised by an exclusive or certified bargaining agent that represents employees of the employer.

(b) That pilot project may be implemented in four counties as designated by the administrative director and may include more than one health care service plan. One county shall be in northern California, one in central California, and two in southern California. Multi-employer, collectively bargained employee welfare benefit plans that operate in one or more of the designated counties, or recognized bargaining agents for state employees that sponsor a welfare benefit plan, may implement a pilot project in all counties in which participants are employed and covered for non-occupational injuries and illnesses.

(c) Notwithstanding the terms of Section 4600, 4601, or any other provision of this article, an employee employed by an employer participating in the pilot project who has elected to enroll in the pilot project shall not have the option of pre-designating a personal physician, other than a physician provided by the licensed health care service plan designated by the participating employer, as his or her treating physician, nor shall an employee have the option of changing to a physician not provided by the health care service plan pursuant to Section 4601. However, this section shall not be construed to limit the requirement under Section 4600 that an employer

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provide treatment reasonably required to cure or relieve the effects of an injury, nor shall this section be construed to prohibit an employee from changing to another provider of health care services during any annual open enrollment period.

(d) The administrative director shall, at the completion of the second year of the pilot project, or sooner if feasible, prepare a preliminary report, and within one year after completion of the pilot project, prepare a final report to the Legislature and the Governor describing the pilot project. The report shall include a review of the following:

- (1) Employer costs.
- (2) Vocational rehabilitation implications of 24-hour care pilot projects.
- (3) Numbers and percentages of employees in pilot worksites that enroll in the plan.
- (4) Incentives used by employers to encourage enrollment in the plan.
- (5) Extent to which dependents of pilot project employees enroll in health plans.
- (6) Determination of employee satisfaction with the pilot program.
- (7) Extent to which employees enrolling in the pilot plan continue to stay within it during the length of the pilot program.
- (8) Differentials in costs of treatment between different types of pilot programs for occupational and non-occupational injuries and illnesses.
- (9) Differentials in costs of treatment and of indemnity benefits among workplaces comparable in size, type of industry, and location, between pilot programs and non-24-hour care for occupational and non-occupational injuries and illnesses.
- (10) Differentials in costs of claims administration between pilot programs.
- (11) Percentage of occupational injury claims litigated and the type of dispute giving rise to litigation.
- (12) How continuing obligations for medical treatment under workers' compensation will be secured after completion of the pilot project.
- (13) Whether the pilot project was or could be utilized by small employers.

The pilot project shall be deemed a success if the administrative director can verify that the information contained in the report required by paragraphs (1) to (13), inclusive, compares favorably with that of employers and employees not included in the pilot project. In order to prepare the report, the administrative director shall prescribe information to be collected by each approved pilot program for submission to the division in a timely manner.

(e) The administrative director shall prepare an itemization of the costs to the division associated with preparation of the report described in subdivision (d). The cost of the report shall be borne by the employers participating in the pilot project, and, if available, by other external sources

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outside of the General Fund. Contribution by the employers shall be apportioned on a per capita basis based upon the number of employees enrolled under the pilot project.

(f) For purposes of this section, "health care service plan" includes health care service plans and disability insurers that offer a managed care product within a pilot project county, workers' compensation insurers as defined in Section 3211 of the Labor Code that offer a managed care product within a pilot project county, multi-employer collectively bargained employee welfare benefit plans that offer a managed care product within a pilot project county, and welfare benefit plans sponsored by recognized exclusive bargaining agents for state employees. Pilot projects covering state employees shall be approved by the state employer and approved pursuant to Part 5 (commencing with Section 22751) of Title 2 of the Government Code. (g) The employer's contract with the health care service plan shall include a surcharge or other provision to cover the cost of the medical care of an injured employee which is required by this division after the employee leaves the contracting employer's employment. (h) Enrollment or subscription in the pilot project may not be canceled or not renewed except in the following:

- (1) Failure to pay the charge for that coverage if the subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.
- (2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting that fraud or deception by another.
- (3) Any other good cause as is agreed upon in the contract between the plan and a group or the subscriber.

(i) Notwithstanding any other provision of this section, no employer that is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law for represented employees, shall contract with a managed care organization for purposes of this section unless authorized to do so by mutual agreement between the bargaining agent and the employer.

CALIFORNIA CODE OF REGULATIONS RELATING to the 24-Hour Care Pilot
SECTIONS 10175-10181

Subchapter 1.7 (commencing with Section 10175) is added to Chapter 4.5 of Division 1 of Title 8 of the California Code of Regulations to read:

§10175. Definitions.

As used in this subchapter:

(a) "Employer" means any person defined as an employer in Section 3300 of the Labor Code who has secured the payment of workers' compensation benefits as required by Section 3700 of the Labor Code.

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(b) "Exclusive provider of care option" means an option chosen by an employee under Section 10180 under which medical, surgical, and hospital treatment for both occupational and non occupational injuries and illness are provided to the employee through one health care service plan.

(c) "Health care service plan" means any of the following which offer a managed care product:

- (1) A health care service plan licensed under Section 1353 of the Health and Safety Code (Knox-Keene Health Care Service Plan Act);
- (2) A disability insurer authorized to transact health insurance or disability income insurance pursuant to Part 2 of Division 2 of the Insurance Code.
- (3) An insurer authorized to transact workers' compensation insurance in California, including the State Compensation Insurance Fund.
- (4) The state or an employer who has secured a certificate of consent to self-insure from the Director of Industrial Relations pursuant to Labor Code Section 3700.
- (5) Multi-employer collectively bargained employee welfare benefit plans or an employee welfare benefit plan sponsored by a recognized exclusive bargaining agent for State employees.

(d) "Managed care product" means a system of medical care which provides for all of the following:

- (1) All medical and health care services required under Section 4600 of the Labor Code in a manner that is timely, effective, and accessible to the employee. This shall include making available to an employee, within 5 days of a request, the services of any type of physician, as defined in Section 3209.3 of the Labor Code, including a chiropractor, following an initial visit with the employee's primary care physician, when treatment for an occupational injury or illness falls within the scope of practice of the requested type of physician.
- (2) Appropriate case management, including direction of injured employees to appropriate medical service providers within a network for all non emergency services.
- (3) Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service, and mechanisms to identify and correct quality deficiencies.
- (4) Adequate methods of quality assurance, peer review and service utilization review to prevent inappropriate or excessive treatment, and exclusion from participation those providers who violate treatment standards.
- (5) Expertise in providing medical reports necessary for the prompt, proper administration of compensation, including those required under Sections 9785 and 10978.
- (6) A procedure for resolving disputes concerning the provision of health care services under the plan, which shall be equivalent to that specified in Section 1368 of the Health and Safety Code.

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- (7) A program involving cooperative efforts by the employees, the employer, physicians, and other participants to promote employee wellness, workplace health and safety, and early return to work.
- (8) Adequate mechanisms to assure coordinated case management goals and incentives among all providers of workers' compensation for employees with occupational injuries and diseases.
- (e) "Principal place of business" means the location at which the majority of the employer's employees are employed.
- (f) "Small employer" means an employer who on at least 50 percent of its working days during the calendar quarter preceding submission of the proposal under which the employer participates in the pilot project employed not more than fifty (50) employees.
- (g) "Traditional health benefit plan" means a plan of medical coverage for non -occupational injuries and illness provided by the employer, through a contract between the employer and a health care provider, or through a purchasing cooperative specifically authorized by state law.
- (h) "Traditional workers' compensation provider" means a health care provider chosen pursuant to Labor Code Section 4600 or 4601.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612,

§10176. Eligible Employers and Employees

- (a) Employers whose principal place of business is in any of the following counties may participate in the pilot project:
 - (1) Los Angeles;
 - (2) San Diego;
 - (3) Santa Clara;
 - (4) Sacramento.
- (b) Employees of employers eligible to participate in the pilot project who are employed in counties other than those enumerated in subdivision (a) are not precluded from participation in the project.
- (c) Nothing in this section shall be construed to prohibit participation by employers whose principal place of business is not within one of the four counties listed in subdivision (a) above if the employer is specifically authorized to do so by statute.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612,

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§10177. Eligible Applicants

(a) Pilot project plan proposals may be submitted to the administrative director by any one or combination of the following entities or authorized agents thereof:

- (1) Employers
- (2) Health care service plans
- (3) Health insurance purchasing cooperatives specifically authorized under state law.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612,

§10178. Pilot Project Proposal Requirements

(a) Proposals submitted to the administrative director for final approval shall include all of the following:

- (1) A description of the manner in which health care services are to be provided, including the administrative and organizational structure, how each component of the managed care product will be provided, and the standards and procedures under which an employee who selects the exclusive provider of care option will be permitted to change health care service plans.
- (2) The business name and tax identification number of the employer or employers, the approximate number and occupations of participating employees, the health care service plan or providers of health care services, and any other parties required in the operation of the proposal. The proposal shall include signed authorizations from all necessary parties, other than the employees, confirming their commitment to the plan. In the case of a proposal under which only small employers will participate, the proposal may specify the method by which employers will be selected to participate in lieu of identifying and obtaining commitments from participating employers and identifying the approximate number and occupations of participating employees.
- (3) The method whereby employees will be informed of their rights and options under the proposal, including the right to obtain a decision from the Workers' Compensation Appeals Board in the case of disputes over compensation for injuries compensable under Division 4 (commencing with Section 3200) of the Labor Code. Materials to be used for this purpose shall be submitted with the proposal. Materials shall include a description of the dispute resolution process, a description of dependent coverage, a description of the method and frequency of employee choice of health care provider, and a description of any other incentives offered to employees by employers to participate in the plan.
- (4) The dispute resolution process under the exclusive provider of care option, including the process made available to employees to voluntarily resolve issues subject to the jurisdiction of the appeals board, as well as the process for resolving disputes which are not subject to the jurisdiction of the appeals board.

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- (5) A description of how dependents will be covered under the proposal, and if co-payments, premium shares, deductibles, or other charges are to be assessed against employees or dependents for non occupational injuries and illness, the amount of such charges and how these charges will be determined and segregated in a manner to assure compliance with subdivision (a) of Section 3751 of the Labor Code.
- (6) The method and frequency of employee choice as to whether the employee will receive medical care under an exclusive provider of care option.
- (7) A description of any incentives offered by an employer to employees to encourage participation in the exclusive provider of care option.
- (8) Verification of agreement to participate executed by an authorized representative of each exclusive or certified bargaining agent which represents employees of the employer.
- (9) The method by which any workers' compensation liability of the employer incurred during the pilot project will be paid after an employee's or employer's participation in the pilot project terminates.
- (10) An agreement to provide the administrative director, in the form and manner prescribed by the Administrative Director, with information necessary to evaluate the plan and compliance with this subchapter.
- (11) An agreement by the participating employers, or by another participating entity on the behalf of these employers, to pay a proportionate share of the cost of the evaluation of the pilot projects approved under this subchapter, based on the number of participating employees. Nothing in this paragraph shall be construed to require participating employers to pay a share of the evaluation cost if other funding sources are authorized by statute and alternative funding is obtained for this purpose.

Note: Authority: Labor Code Sections 133, 4612, 5307.3

Reference: Labor Code 4612

§10179. Selection of Proposals; Priorities

- (a) Initial applications will be accepted from the date the Request for Applications is issued until March 31, 1994.
- (b) The following will be given priority in selecting participants in the pilot project:
 - (1) Joint labor-management proposals.
 - (2) Proposals targeting employers who have previously not offered health benefits for non-occupational injuries and illness to their employees.
 - (3) Proposals which include appropriate control groups to assist the evaluation process.
 - (4) Proposals which provide for coordinated administration of indemnity benefits, as well as medical benefits, including workers' compensation temporary disability benefits, state disability

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insurance benefits, and private disability benefits, while retaining separate administration of the compensation required under Division 4 (commencing with Section 3200) of the Labor Code.

- (5) Proposals which will operate in more than one pilot project county.
- (6) Proposals which provide parity in coverage between occupational and non-occupational injuries and illness.
- (7) Proposals which will commence on January 1, 1994.

(c) Proposals approved for participation in the pilot project shall commence no earlier than January 1, 1994 and shall terminate no later than December 31, 1997.

Note: Authority: Labor Code Sections 133, 4612, 5307.3
Reference: Labor Code 4612

§10180. Employee Choice Of Plans

(a) An employee participating in a proposal approved by the administrative director must be offered a choice between the following:

- (1) Receiving medical benefits under an exclusive provider of care option for both occupational and non-occupational injuries and illness;
- (2) Receiving medical benefits for non-occupational injuries and illness from a traditional health benefit plan and receiving medical treatment for occupational injuries and illness from a traditional workers' compensation provider.

(b) Employees may be permitted to choose between the two options specified in subdivision (a) in the following ways:

- (1) The employee selects an option only once, either (i) before the plan begins in the case of current employees, or (ii) at the time of employment in the case of persons employed after the initial selection period for current employees.
- (2) After the initial election, the employee is permitted to change options annually, during an open enrollment period made available to all participating employees.

(c) Nothing in this section shall be construed to preclude an employee from changing plans at any time for good cause, as specified in the approved pilot project proposal or in the rules of the health care service plan.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.
Reference: Labor Code 4612

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§10181. Records, Claims Administration, Auditing, and Termination

(a) Nothing in this subchapter shall relieve any employer, health care provider, or their agents from any of the requirements or obligations contained in Division 1 (commencing with Section 1) of this Title, except for the requirements of Sections 9780.1, 9781, and 9782 to the extent an approved pilot project proposal conflicts with the requirements of these sections.

(b) Administration and accounting of the payment of workers' compensation benefits under this pilot project shall be solely for the purpose of complying with the workers' compensation laws of the State of California and shall be separate from the administration of other employee welfare benefits within the meaning of 29 U.S.C. Section 1002 (1). However, any benefit provided by a government plan, church plan, or benefits plan maintained solely for the purpose of compliance with unemployment compensation or disability insurance laws, within the meaning of 29 U.S.C. 1003, may be combined with the administration of workers' compensation under an exclusive provider of care option.

(c) Nothing in this subchapter or a pilot project plan shall be construed to relieve any person, including an employer or physician, from any reporting requirements concerning occupational injuries or illness, or to preclude or in any way inhibit the adjudication of issues involving occupational injuries, including whether an injury or illness is compensable under Division 4 (commencing with Section 3200) of the Labor Code, before the Workers' Compensation Appeals Board.

(d) An employer's participation in this pilot project shall terminate automatically, without any action by the administrative director, when an employer fails to secure the payment of workers' compensation in the manner prescribed by Section 3700 of the Labor Code.

Note: Authority: Labor Code Sections 133, 3700, 4612, 5307.3

Reference: Labor Code Sections 3700, 4612, 5300, 6409, 6409.1.

Florida

440.135 Pilot programs for medical and remedial care in workers' compensation-

(1) It is the intent of the Legislature to determine whether the costs of the workers' compensation system can be effectively contained by monitoring more closely the medical, hospital, and remedial care required by s. 440.13, while providing injured workers with more prompt and effective care and earlier restoration of earning capacity without diminution of the quality of such care. It is the further intent of the Legislature to determine whether the total cost to an employer that provides a policy or plan of health insurance and a separate policy or plan of workers' compensation and employer's liability insurance for its employees can be reduced by combining both coverages under a policy or plan that provides 24-hour health insurance coverage as set forth in this section. Therefore, the Legislature authorizes the establishment of one or more pilot programs to be administered by the Department of Insurance after consulting with the division. Each pilot program shall terminate 2 years after the first date of operation of the program, unless extended by act of the Legislature. In order to evaluate the feasibility of implementing these pilot programs, the Department of Insurance shall consult with the division regarding:

(a) Establishing alternate delivery systems using a health maintenance organization model, which includes physician fees, competitive bidding, or capitation models.

(b) Controlling and enhancing the selection of providers of medical, hospital, and remedial care and using the peer review and utilization review procedures in s. 440.13(1) to control the utilization of care by physicians providing treatment pursuant to s. 440.13(2)(a).

(c) Establishing, by agreement, appropriate fees for medical, hospital, and remedial care pursuant to this chapter.

(d) Promoting effective and timely utilization of medical, hospital, and remedial care by injured workers.

(e) Coordinating the duration of payment of disability benefits with determination made by qualified participating providers of medical, hospital, or remedial care.

(f) Initiating one or more pilot programs under which participating employers would provide a 24-hour health insurance policy to their employees under a single insurance policy or self-insured plan. The policy or plan must provide a level of health insurance benefits which meets criteria established by the Department of Insurance but which provides medical benefits for at least occupational injuries and illnesses comparable to those required by this chapter and which may use deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical care received by the employee, notwithstanding any other provisions of this chapter. The policy or plan may also provide indemnity benefits as specified in s. 440.38(1)(e). The employer shall pay the entire premium for the 24-hour health insurance policy or self-insured plan other than the portion of the premium which relates to dependent coverage.

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(g) Other methods of monitoring reduced costs within the workers' compensation system while maintaining quality care.

(2) The Department of Insurance, after consulting with the division, may, without a bidding process, negotiate and enter into such contracts as may be necessary or appropriate in its judgment to implement the pilot program.

(3) The Department of Insurance may also accept grants and moneys from any source and may expend such grants and moneys for the purposes of the program.

(4) No provision of the pilot programs may vary the methods for calculating weekly payments for disability compensation under this chapter. Likewise, no provision of the pilot programs shall limit the right to a hearing under s. 440.25.

(5) The Department of Insurance shall make an interim report on or before December 1, 1991, and a final report on or before the termination date specified in subsection (1) to the Speaker of the House of Representatives, the President of the Senate, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Governor, on the activities, findings, and recommendations of the Department of Insurance relative to the pilot programs. The Department of Insurance shall monitor, evaluate, and report the following information regarding physicians, hospitals, and other remedial care providers:

- (a) Cost savings.
- (b) Effectiveness.
- (c) Effect on earning capacity and indemnity payments.
- (d) Complaints from injured workers and providers.
- (e) Concurrent review of quality of care.
- (f) Other pertinent matters.

The information from the pilot programs shall be reported in a format to permit comparisons to other similar data.

History. --s. 19, ch. 90-201; s. 17, ch. 91-1; s. 19, ch. 93-415.

Georgia

34-9-122.1

- (a) Notwithstanding any provision of this chapter to the contrary, workers' compensation health benefits pilot projects are authorized under the provisions of this Code section.
- (b) The Commissioner of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with workers' compensation medical payments benefits through comprehensive health insurance that covers workplace injury and illness. The Commissioner of Insurance shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this chapter. The Commissioner shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.
- (c) The comprehensive health insurance may provide for health care by a health maintenance organization or a preferred provider organization. The premium must be paid entirely by the employer. The program may use deductibles, coinsurance, and copayment by the employees not to exceed \$5.00 per visit or \$50.00 maximum per occurrence.
- (d) The Commissioner of Insurance shall report annually to the standing committees of the General Assembly having jurisdiction over insurance and labor matters by November 1 on the status of any pilot projects approved by the Commissioner.

Kentucky

216.2960 Pilot projects for twenty-four hour health coverage -- Authority for administrative regulations.

(1) By January 1, 1995, the Department of Insurance shall promulgate administrative regulations pursuant to KRS Chapter 13A authorizing the establishment by March 1, 1995, of pilot projects for twenty-four (24) hour health coverage. The total number of participants in the pilot projects cannot exceed five percent (5%) of all insured persons who are covered both by workers' compensation and general health insurance. The administrative regulations for the pilot projects shall provide that:

(a) A twenty-four (24) hour policy may cover general health care for purposes of general health insurance, auto insurance, workers' compensation, or health care normally covered by any line of insurance written in the Commonwealth;

(b) A twenty-four (24) hour coverage policy shall not contain deductibles or copayments for medical services or treatment for work-related injuries or diseases; and

(c) There shall be no transfer of liabilities or expenses between or among particular lines of insurance whose medical or health components have been combined into a twenty-four (24) hour coverage for health care.

(2) No policy for twenty-four (24) hour coverage shall become effective until it is reviewed and approved by the Department of Insurance.

(3) Notwithstanding any other provision of the Kentucky Revised Statutes to the contrary, each insurer authorized or licensed to write insurance in the Commonwealth shall provide any information requested by the department for the purpose of developing a twenty-four (24) hour health policy.

(4) The purchase of a twenty-four (24) hour health policy shall not constitute an exemption from statutory provisions which require other nonmedical insurance coverage. However, an insurance carrier shall reduce its premium for insurance coverage written without the medical or health care component. Notwithstanding the provisions of Subtitle 13 of KRS Chapter 304, the premium reduction required in this subsection shall be subject to the approval of the commissioner of the Department of Insurance.

(5) If an employer obtains a twenty-four (24) hour health insurance policy, pursuant to this section, to secure payment of compensation for medical care and treatment under KRS Chapter 342, the employer shall also procure an insurance policy which shall provide indemnity benefits to ensure that the total coverage afforded by both the twenty-four (24) hour insurance policy and the policy providing indemnity benefits, shall provide the total compensation required by KRS Chapter 342.

(6) The participants in a pilot project for twenty-four (24) hour health coverage shall comply with periodic reporting requirements of the Department of Insurance. (7) Each insurer authorized or licensed to write insurance in the Commonwealth shall cooperate with the department and shall

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provide any information requested by the department for the purpose of studying twenty-four (24) hour health policy.

(8) Each agency of state government shall cooperate with the department if requested to provide information for the purposes of this section.

Effective: July 15, 1996

History: Amended 1996 Ky. Acts ch. 371, sec. 21, effective July 15, 1996. -- Created 1994 Ky. Acts ch. 512, Pt. 6, sec. 19, effective July 15, 1994.

Louisiana

22.21 Pilot programs; Department of Insurance; establishment

The Department of Labor and the Department of Insurance, conjunctively, after consultation with the office of workers' compensation administration in the Department of Labor, are hereby authorized to establish no more than five pilot health insurance programs, which may consist of groups or associations of employers for twenty-four-hour insurance coverage that shall terminate five years after the first date of operation of the program, unless extended by an act of the legislature. The pilot program shall monitor the medical, hospital, and remedial care of employees and the provision of prompt, effective care and earlier restoration of earning capacity without diminution of the quality of that care of the injured or disabled employee. In order to implement the pilot health insurance program for employees, the Department of Labor and the Department of Insurance, conjunctively, shall:

- (1) Initiate an initial pilot project for reimbursement to hospitals on diagnostic-related groups upon determination that it is cost-effective and a statistically valid method for reimbursement.
- (2) Establish alternate delivery systems using a health maintenance organization model, which includes physician fees, competitive bidding, or capitation models.
- (3) Provide for the selection of providers of medical, hospital, and remedial care and utilization review procedures established pursuant to R.S. 40:2725 to control the utilization of care by physicians providing treatment pursuant to R.S. 23:1121 through 1212.
- (4) Establish by written agreement all appropriate fees for medical, hospital, and remedial care pursuant to pertinent worker's compensation laws.
- (5) Promote effective and timely utilization of medical, hospital, and remedial care of and by insured persons under the pilot program.
- (6) Coordinate the duration of payment of disability benefits with a determination by qualified participating providers of medical, hospital, or remedial care.
- (7) Establish other methods of monitoring the reduction of costs within the worker's compensation system for health and disability care while maintaining a quality of care.
- (8) Provide public input and comment concerning the benefits, deductibles, pre-existing conditions exclusions, and related components of the health care portion of the twenty-four-hour employee insurance pilot program.

Acts 1993, No. 656, § 1; Acts 1997, No. 1097, § 1, eff. July 14, 1997.

22.22 Pilot program; certain provisions

A. The Department of Labor and the Department of Insurance, conjunctively, may negotiate and enter into such contracts or agreements as may be necessary or appropriate to implement the pilot program herein.

B. The Department of Labor and the Department of Insurance, conjunctively, may also accept grants and monies from any source as allowed by law and may expend such grants and monies for the purposes of the program.

C.(1) No provision of the pilot program shall vary the methods for calculating weekly payments for disability compensation required under R.S. 23:1221 et seq.

(2) No provision of the pilot program shall limit or abrogate the right to a hearing concerning benefits, coverage, or quality of care under state law. Furthermore, each pilot program shall incorporate within its terms all provisions of the Louisiana Workers' Compensation law including but not limited to the employee's rights with respect to selection of health care providers.

(3) Except as otherwise provided in Paragraph (2) of this Subsection, all pilot health insurance programs under this Section shall be subject to the provisions of R.S. 23:1121 through 1127.

D. The Department of Labor and the Department of Insurance, conjunctively, shall issue an interim report on or before December 1, 1994, and a final report on or before the termination date of August 15, 1995, to the speaker of the House of Representatives, the president of the Senate, the members of the respective committees on insurance in the House of Representatives and Senate, and the governor, on its activities, findings, and recommendations about the pilot program herein. The Department of Labor and the Department of Insurance, conjunctively, shall monitor, evaluate, and report the following information regarding physicians, hospitals, facilities, and other medical care providers:

- (1) Cost savings.
- (2) Effectiveness.
- (3) Effect on earning capacity and indemnity payments.
- (4) Complaints from injured workers and providers.
- (5) Concurrent review of quality of care.
- (6) Other pertinent matters.

E. The information from the pilot program shall be reported in a format to permit comparisons to other similar data or states.

Acts 1993, No. 656, § 1; Acts 1997, No. 1097, § 1, eff. July 14, 1997.

22.23 Pilot program; requirements, contents

A. Every employer under the pilot program shall secure the payment of compensation by obtaining a twenty-four-hour health insurance policy which shall provide medical benefits authorized by R.S. 22:21 through 22 and which shall meet criteria established conjunctively by the Department of Labor and the Department of Insurance by rule or regulation, promulgated pursuant to the Administrative Procedure Act.¹

B. The twenty-four-hour health insurance policy herein may provide for health care by a health maintenance organization established by R.S. 22:2001 et seq. or a preferred provider organization established pursuant to R.S. 40:2201 et seq.

C.(1) The premiums for any non-occupational portion of a health insurance policy under this Section may be shared by the employer and employees in accordance with the terms of the policy or plan. All premiums for the workers' compensation portion of the pilot program shall be paid by the employer as required under R.S. 23:1163.

(2) The insurer of any pilot program under this Section shall maintain records to assure compliance with Paragraph (1) of this Subsection.

D. The twenty-four-hour health insurance policy may utilize deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical services received by the employee. However, such policy shall exempt the employee from deductibles and coinsurance provisions related to work or occupational injuries or diseases.

E. In the event the employer purchases a twenty-four-hour health insurance policy to secure payment of compensation as to medical benefits, the employer shall also obtain an insurance policy which shall provide indemnity benefits, so that the total coverage afforded by both the twenty-four-hour health insurance policy and the policy providing indemnity benefits, shall provide the total compensation required by state law.

F. Any insurance policy issued under a pilot program shall insure the employer's obligation to a named insured throughout the entire period of any illness or disability, specifically, but not limited to the duration of benefits as provided under the Louisiana Workers' Compensation law or the Louisiana Insurance law for an employee and his dependents.

Acts 1993, No. 656, § 1; Acts 1997, No. 1097, § 1, eff. July 14, 1997.

¹R.S. 49:950 et seq.

Oklahoma

Statute §85-14.1. Integrated management of claims pilot program.

The Insurance Commissioner of the State of Oklahoma shall establish a pilot program of integrated management of an employer's workers' compensation and group health insurance claims by an insurer authorized to do business in the state and shall promulgate such rules as may be necessary to implement the provisions of this section. The integrated management of such claims shall in no event affect any benefits, rights or coverage established pursuant to a workers' compensation insurance policy.

[1]Added by Laws 1993, c. 349, § 8, eff. Sept. 1, 1993.

Maine

Statute 39/A Section 403(2)

2. *(TEXT EFFECTIVE UNTIL 1/1/05)* **Pilot projects.** Workers' compensation health benefits pilot projects are authorized under the following provisions.

A. The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with health care benefits covering workplace injury and illness and nonworkplace injury and illness and other health care benefits, or health care and indemnity benefits covering workplace injury and illness and nonworkplace injury and illness and other health care and indemnity benefits, in comprehensive pilot projects. The health care and indemnity benefits may be provided by: organizations authorized to do business under Title 24; insurers or health maintenance organizations authorized to do business under Title 24-A; employee benefit plans; and benefit plans of employers who self-insure under this section. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits, or medical and indemnity benefits depending on the pilot project proposal, upon injured employees that are equal to or greater than the benefits available under this Title. Indemnity benefits may only be modified in those pilot projects providing medical and disability benefits for all workplace and nonworkplace diseases and injuries. The superintendent shall revoke approval if the pilot project fails to deliver the benefits contained in the proposal. A pilot project proposal that provides indemnity benefits deviating in any way from the indemnity benefits provided under this Title must include in its application to the superintendent for approval under this section a methodology for identifying both the costs and benefits of the deviations and a methodology for comparing those costs and benefits to the costs and benefits provided under this Title. The superintendent may not approve a pilot project that does not provide, as determined by the superintendent, an adequate basis for making the foregoing cost-benefit comparison between the pilot project and this Title. [1995, c. 277, §1 (amd).]

B. Notwithstanding the provisions of section 206, the comprehensive health care benefits pilot project may allow for case management and cost control mechanisms, including the use of preferred provider organizations. The premium for coverage of the employee for benefits available under this Title must be paid entirely by the employer. The premium for other benefits may be paid by the employer, the employee or the employer and employee together. The deductible for the health care of the employee may not exceed a maximum of \$50 per injury or illness and the coinsurance may not exceed \$5 per treatment of the employee by the health care provider. [1995, c. 277, §1 (amd).]

C. The Superintendent of Insurance shall report annually to the joint standing committees of the Legislature having jurisdiction over banking and insurance and labor matters by November 1st on the status of any pilot projects approved by the superintendent. [1991, c. 885, Pt. A, §8 (new); §§9-11 (aff).]

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D. Unless continued or modified by law, this subsection is repealed January 1, 2005. [2001, c. 48, §1 (rpr); §2 (aff).]

[2001, c. 48, §1 (amd); §2 (aff).]

2. (TEXT REPEALED 1/1/05) Pilot projects. [T. 39-A, §403, sub-§2, paragraph D (rp).]

Maine - Chapter 690 Rule: 24-HOUR COVERAGE PILOT PROJECTS

1. Purpose and scope

This Rule establishes standards, procedures, and conditions of approval for pilot projects to deliver comprehensive health care benefits covering both workplace and non-workplace conditions. The Rule applies to all employers electing to secure any part of their Maine workers' compensation liabilities through participation in pilot projects pursuant to 39-A M.R.S.A. § 403(2), and to all benefit providers and service providers participating in pilot projects.

2. Authority

This Rule is adopted pursuant to 24-A M.R.S.A. § 212 and 39-A M.R.S.A. § 403(2).

3. Definitions

Except where the context clearly indicates otherwise, the following terms have the following meanings:

A. Approved pilot project or pilot project means a program, established pursuant to this Rule, to implement on an experimental basis and to evaluate an arrangement that integrates the delivery of health benefits for work-related and non-work-related conditions.

B. Approved benefit provider or benefit provider means any of the following entities, if it has been authorized by the Superintendent pursuant to this Rule to provide benefits for all or part of an approved pilot project:

i) an authorized carrier, meaning an insurance company, nonprofit health service organization, or health maintenance organization authorized to do business in Maine pursuant to 24 M.R.S.A. § 2301 or 24-A M.R.S.A. §§ 404 or 4203; or

ii) a regulated self-insurer, meaning a multiple-employer welfare arrangement or an individual or group workers' compensation self-insurer

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authorized to provide benefits in Maine pursuant to 24-A M.R.S.A. § 6602 or 39-A M.R.S.A. § 403(3) or 403(4); or

iii) a participating ERISA plan, meaning a single-employer self-funded employee welfare benefit plan or bona fide Taft-Hartley trust, otherwise exempt from state regulation pursuant to 29 U.S.C. 1144(a), which has entered into a binding agreement to comply with the provisions of this Rule in return for approval to take part in a pilot project.

C. Self-insurer means a regulated self-insurer or participating ERISA plan.

D. participating employer, participant, or employer means an employer that has been authorized by the Superintendent pursuant to this Rule to secure all or part of its Maine workers' compensation liabilities by participating in an approved pilot project.

E. Health benefits include workers' compensation medical benefits as defined in 39-A M.R.S.A. § 206.

F. Integrated 24-hour medical coverage plan or integrated plan means a policy, contract, or employee benefit plan, issued by an approved benefit provider, which provides at a minimum all health benefits required by this Rule. Additional benefits provided by an integrated plan may include disability coverage, which may in turn consist of or include complete or partial workers' compensation indemnity coverage.

G. Coordinated 24-hour medical coverage plan or coordinated plan means an arrangement consisting of more than one policy, contract, or employee benefit plan, issued by one or more approved benefit providers, which in combination provide at a minimum all health benefits required by this Rule, together with an administrative mechanism approved by the Superintendent which provides a single contact point for covered employees and a single contact point for health care providers. A coordinated plan may include a component which provides complete or partial workers' compensation indemnity coverage, either separately or as part of a broader disability coverage.

H. Wraparound indemnity coverage means a workers' compensation insurance policy or approved workers' compensation self-insurance plan, issued or established in conjunction with an integrated or coordinated 24-hour medical coverage plan, which provides all workers' compensation benefits not provided by the 24-hour medical coverage plan.

I. Approved service provider or service provider means any person or entity, other than an approved benefit provider or participating employer, whose services are an essential component of a pilot project, including without limitation any preferred

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provider organization, claim administrator, or information systems provider taking part in the pilot project.

J. Claim administrator means the entity responsible for receiving, processing, and managing payment of claims under an integrated or coordinated 24-hour medical coverage plan.

K. Alternative benefit design means any provision in an integrated or coordinated 24-hour medical coverage plan which provides for medical or disability benefits that differ from the minimum benefits otherwise required under the Workers' Compensation Act, Title 39-A M.R.S.A.

4. General requirements

A. No employer may use the "pilot project" option set forth in 39-A M.R.S.A. § 403(2) to secure all or any part of its workers' compensation liabilities unless the employer is approved by the Superintendent pursuant to this Rule to participate in a pilot project that is approved by the Superintendent pursuant to this Rule.

B. Upon approving an application to participate in a pilot project, the Superintendent shall specify the effective date of the approval. During the time the approval is in force, the employer has secured compensation within the meaning of 39-A M.R.S.A. § 403 as to all employees who are covered by the pilot project. Once the approval of the pilot project or the employer's participation in the pilot project terminates or is suspended or revoked, the employer must secure its workers' compensation liabilities through one of the other mechanisms authorized by statute. Nothing in this Rule shall be construed as limiting or expanding the exclusive remedy provisions of 39-A M.R.S.A. §§ 104 and 408. This Rule does not apply to any federal workers' compensation program, unless the applicable federal law incorporates Maine law by reference.

C. Application to the Superintendent for pilot project approval and for annual renewal shall be made by the proposed participating employer or group of employers in the manner prescribed by the Superintendent. The factors to be considered by the Superintendent, in determining the suitability of a proposed pilot project, shall include, without limitation:

- i) the project's potential to work to the mutual advantage of workers, employers, health care providers, and insurers by reducing administrative costs; by eliminating or minimizing differences in the delivery, administration, and financing of health services for work-related and non-work-related conditions; and by improving quality, efficiency, and the timely provision of benefits;

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- ii) the project's likely efficacy in testing empirically a specific concept or concepts relevant to the goal of providing quality health care to all in an equitable and cost-effective manner, and its contribution to the diversity of participants and plan designs available for evaluation; and
 - ii) the ability of the participating benefit providers and service providers to provide effective and reliable funding and administration for the pilot project, and to assist in the evaluation of the pilot project;
- D. Each pilot project must include, at a minimum:
- i) an integrated or coordinated 24-hour medical coverage plan which, except to the extent the minimum requirements are expressly modified by this Rule, provides health benefits for work-related conditions to all covered employees sufficient to satisfy the requirements to 39-A M.R.S.A. § 206, as amended, and provides appropriate health benefits for non-work-related conditions on terms satisfactory to the Superintendent;
 - ii) wraparound indemnity coverage which provides all workers' compensation benefits required by Title 39-A M.R.S.A. and not provided either directly or through an approved alternative benefit design by the 24-hour medical coverage plan (a separate wraparound indemnity policy is not required if all required indemnity benefits are provided by, the integrated plan or the workers' compensation portion of the coordinated plan); and
 - iii) a system for data collection and reporting satisfying the requirements set forth in this Rule.
- E. The application must be accompanied by copies of the following documents:
- i) the 24-hour medical coverage plan description to be furnished to eligible employees;
 - ii) the wraparound indemnity policy, if any, and appropriate procedures for coordination between the indemnity carrier and the 24-hour medical coverage plan;
 - iii) contracts, if any, between the claim administrator and all benefit providers other than the claim administrator;
 - iv) a description of any cost control mechanisms, including copies of any contracts with health care providers or utilization review entities;

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- v) provisions for ensuring continuity of coverage and payment of all future benefits required by the workers' compensation Act in the event of the termination or substantial restructuring of the pilot project; and
- vi) if the pilot project includes an alternative indemnity benefit design, a methodology for identifying the costs and benefits of the deviations from the indemnity benefits otherwise required by the Workers' Compensation Act, and for comparing the costs and benefits of the alternative benefit design to the costs and benefits of the benefit design otherwise required by the Workers' Compensation Act; and
- vii) such other documents as the Superintendent may reasonably request.

F. The term of approval for participation in a pilot program shall be one year, unless the Superintendent orders a shorter term in a particular case. If an employer joins a group pilot project in midyear, the renewal date for its participation shall be the group's renewal date.

G. Approval of pilot projects shall be renewed annually upon demonstration to the Superintendent of satisfactory performance during the previous year and continued ability to carry out the goals of the pilot project during the coming year. Renewal applications must be filed at least thirty days before the scheduled expiration date.

H. Any modification to an existing pilot project must be approved by the Superintendent before implementation. Any participating entity must immediately notify the Superintendent of any change in circumstances materially affecting the operation of the plan, including without limitation changes in financial position, changes in operations, and revisions to pertinent collective bargaining agreements.

I. Each benefit provider and service provider must acknowledge that the Superintendent may as necessary review its records and operations relating to an approved pilot project for the purpose of determining compliance with this Rule and with the terms of approval of the pilot project.

J. The Superintendent shall notify the Workers' Compensation Board of all pending applications, approvals, modifications, and terminations of pilot projects, all enforcement actions by the Superintendent and all adjudicatory proceedings initiated pursuant to the Rule, and all litigation in which the validity of this Rule has been challenged.

5. Approved benefit providers and service providers

A. Any approved benefit provider or service provider must demonstrate to the Superintendent that it has the financial strength and administrative resources necessary to

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fulfill its obligations under the pilot project, and that it has sufficient experience providing benefits or services of a type reasonably similar to the benefits or services it proposes to provide. Approval to provide pilot project benefits or services is discretionary and not a matter of right.

B. If a benefit provider is an insurer, it must be authorized to transact health, disability, or workers' compensation insurance in the State of Maine.

C. If the benefit provider is a self-insurer, any integrated plan or wraparound indemnity coverage, and any portion of a coordinated plan which provides any benefits payable under the Maine Workers' Compensation Act, Title 39-A M.R.S.A., must maintain full funding consistent with an actuarial analysis approved by the Superintendent, and must comply fully with all other requirements of 39-A M.R.S.A. § 403 and Bureau of Insurance Rule 250, except to the extent those requirements are expressly modified by the Superintendent for good cause shown. Any such modification of the self-insurance requirements must result from the unique features of the benefit plan and may not impair the rights of covered employees.

D. In order to be an approved benefit provider for any approved pilot project pursuant to this Rule, an ERISA plan must agree to comply with all applicable provisions of this Rule. The agreement shall specify that the plan is operated for purposes of compliance with Maine workers' compensation law and shall waive any claim in any forum that federal law preempts the jurisdiction of the Maine Superintendent of Insurance and Maine Workers' Compensation Board, or the validity or applicability of any statute or rule adopted or enforced by either agency, relating to the 24-hour pilot project. If the agreement to comply with this Rule and submit to the jurisdiction of the Superintendent of Insurance and Workers' Compensation Board is held invalid or otherwise terminates for any reason, approval of the underlying pilot project terminates immediately and automatically, and each employer participating in that project must either obtain a valid Maine workers' compensation insurance policy or structure its workers' compensation self-insurance program in full compliance with 39-A M.R.S.A. § 403 and Bureau of Insurance Rule 250, as amended.

E. Notwithstanding the intent of this Rule to encourage the investigation of innovative plan designs, the Superintendent may disapprove a benefit plan, or order its restructuring, if the unusual structure of the plan hinders effective actuarial or financial analysis to the extent that the Superintendent finds that the plan's soundness cannot be evaluated to an appropriate confidence level.

F. All approved service providers, to the extent the services to be provided require licensure, registration, or other authorization under Maine law, must be properly licensed or otherwise authorized in the State of Maine, and must comply fully with all legal requirements applicable to providers of such services except to the extent that the requirements are within the jurisdiction of the Superintendent and are expressly modified

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by the Superintendent for good cause shown, for reasons resulting from the unique features of the pilot project and not impairing the rights of covered employees.

6. Scope of coverage

A. A pilot project shall cover all employees of the participating employer's Maine operations, except in circumstances where there is no discriminatory impact on employees and where the nature and level of participation will permit a meaningful evaluation of the project, including but not limited to the following:

- i) where employees are divided into two comparable groups for evaluation purposes, one covered by the pilot project and the other by conventional plans;
- ii) where it would be unduly burdensome or otherwise inappropriate to include all Maine worksites or all classes of employees within the pilot project; or
- iii) where all eligible employees are offered the same choice of benefit plans, one of which is the pilot project.

B. With respect to workers' compensation benefits, the full premium or other cost of coverage must be paid by the employer for all covered employees. However, deductibles, copayments, and other cost control mechanisms are permitted to the extent authorized by this Rule.

C. Except for a claim which has been accepted or is being paid by a workers' compensation carrier outside the scope of the pilot project, no otherwise covered claim may be denied or delayed on the ground that the claimant's condition is work-related. The benefit provider's recourse, in the event another workers' compensation carrier is determined to be liable for all or part of the claim, shall be through subrogation or apportionment. However, with respect to work-related conditions, the workers' compensation component of a pilot project has primary liability only when the claimant is an employee and the condition has arisen out of employment with the participating employer during the period in which pilot project coverage is in force, and without prejudice to the rights of subrogation, apportionment, and coordination of benefits that are available to any workers' compensation carrier similarly situated.

D. Pilot projects shall provide for coordination of benefits, other than for work-related conditions, in accordance with plan provisions consistent with standard industry practice and approved by the Superintendent, subject to such rules as the Superintendent may adopt and other applicable laws.

7. Operation of 24-hour medical coverage plans

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- A. Each participating employer must provide all eligible employees a detailed description of the 24-hour medical coverage plan, including the scope of employee and dependent coverage, premiums or other charges, procedures for filing claims, and all applicable cost control mechanisms, including deductibles, copayments, managed care, and utilization review procedures.
- B. The plan description must be accompanied by a concise and understandable summary, which shall include a prominent explanation of all relevant distinctions between the plan's coverage of work-related and non-work-related conditions. When the plan terminates or the employee leaves the plan, all rights to continuation or conversion of health benefits under applicable federal or state law exclude coverage for work-related conditions; such conditions shall continue to be covered on an ongoing basis by the appropriate benefit provider under the plan, to the full extent required under the Workers' Compensation Act, and the plan description shall include a clear statement to that effect.
- C. The plan must designate a claim administrator, which shall receive and process all claims, and manage all payments due under the plan. The claim administrator may be either a participating benefit provider or a third party, and must have authority in this State to perform the duties assumed under the terms of the pilot project.
- D. The pilot project shall include a mechanism, satisfactory to the Superintendent, for resolving disputes by claimants. The plan description provided to employees shall provide a clear explanation of the procedures for internal dispute resolution and for appealing an adverse determination. The claim administrator may also establish a mechanism for resolution of coverage disputes between different benefits plans within the pilot project. Nothing in this Rule shall be construed as superseding or restricting the jurisdiction of the Workers' Compensation Board to determine whether the claimant's condition is work-related or the extent of the claimant's entitlement to workers' compensation benefits.
- E. No pilot project may be structured or operated in a manner that inhibits or discourages workers from reporting work-related injuries, or inappropriately directs claims away from or into the workers' compensation component of a 24-hour medical coverage plan. The claim administrator must take all reasonable measures to ascertain promptly whether there is reason to believe that a claim for benefits arose in the course of employment, and must give timely notice of all potentially work-related claims to the employer, on behalf of the claimant, in a manner sufficient to satisfy the 90-day requirement of 39-A M.R.S.A. § 301. The claim administrator must immediately report all notices of injury to the carrier or self-insurer providing indemnity coverage, and is responsible for compliance on behalf of the employer with all Workers' Compensation Board reporting requirements, unless the terms of the pilot project as approved by the Superintendent assign that responsibility to the indemnity carrier.

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F. Notice of an injury sustained in the course of employment with the participating employer, given by a covered employee to the claim administrator within the time and in the manner specified by the plan, shall constitute actual knowledge by the employer's agent within the meaning of 39-A M.R.S.A. § 302. Once the plan has received timely notice that the claimant considers a claim to be work-related, any payment made on that claim shall constitute a benefit payment within the meaning of 39-A M.R.S.A. § 306, unless the claim administrator has given clear written notice to the claimant, in a form approved by the Superintendent after consultation with the Workers' Compensation Board, explaining that the workers' compensation claim has been controverted, that any future payments on the claim are made under the non-occupational provisions of the plan, and that the claimant's right to file a petition with the Workers' Compensation Board will be governed by a two-year statute of limitations.

8. Cost control mechanisms and Other Alternative Benefit Designs

A. A pilot project may include appropriate cost control mechanisms as approved by the Superintendent upon a determination that they do not interfere with the employees' right to comprehensive and continuing medical benefits for work-related conditions. Cost control mechanisms may include without limitation preferred provider arrangements, utilization review services, and other managed care arrangements, and deductibles or copayments. For conditions arising out of employment with the participating employer during the period in which pilot project coverage is in force, deductibles may not exceed \$50 per injury or illness, and copayments may not exceed \$5 per treatment.

B. Cost control mechanisms and other alternative benefit designs may be approved only if they have been bargained collectively, employee participation in the pilot project is voluntary, or meaningful employee consent is otherwise demonstrated.

C. Utilization review services must comply with the requirements of Bureau of Insurance Rule 520, and must also comply with the requirements of 39-A M.R.S.A. § 210 and any applicable rules adopted by the Workers' Compensation Board governing utilization review unless those requirements are specifically modified by the Superintendent for good cause shown, after consultation with the Workers' Compensation Board.

D. Reimbursement for medical services for work-related conditions may not exceed the limits established by 39-A M.R.S.A. § 209 and any rules adopted there under by the Workers' Compensation Board, unless those requirements are specifically modified by the Superintendent for good cause shown, after consultation with the Workers' Compensation Board.

E. No alternative benefit design may be approved unless the Superintendent determines, after consultation with the Workers' Compensation Board, that

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- I) the overall level of benefits, taking into account both amount and duration, remains equal to or greater than the level of benefits otherwise required under the Workers' Compensation Act; and
- ii) benefit levels are not modified in a manner that discriminates unfairly against any employee or class of employees.

The level of benefits may be evaluated actuarially, on a prospective basis, but must be considered from the perspective of the employee and not from the perspective of the workforce as a whole. Any alternative indemnity benefit design must be an integral feature of a disability coverage plan providing benefits for both workplace and nonworkplace conditions.

9. Evaluation of pilot project

A. The Superintendent, in consultation with pilot project participants and the Workers' Compensation Board, shall develop a plan for evaluating the ability of pilot projects to enhance the delivery and improve the cost effectiveness of medical services for workers and employers. All pilot project participants must agree to participate in the evaluation process as a condition of plan approval.

B. The evaluation criteria for comparing 24-hour coverage plans to other methods of providing coverage plans shall include, but not be limited to:

- i) the cost of workers' compensation and group health coverage, and allocated loss adjustment expenses and related administrative services;
- ii) the nature, extent of utilization, and timeliness of benefits provided to covered persons;
- iii) return-to-work results;
- iv) the cost and frequency of claims, and how costs are allocated;
- v) the cost and frequency of litigation and other claim disputes;
- vi) variations in treatment and costs between compensable and non-compensable injuries;
- (vii) the extent to which any savings are attributable to the efficiencies of using a single delivery system, and the extent to which they are the product of employee contributions and managed care provisions; and

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(viii) satisfaction levels among participating workers, employers, insurers and medical service providers.

C. The workers' compensation statistical advisory organization designated by the Superintendent pursuant to 24-A M.R.S.A. § 2382-B(2) shall develop, in consultation with the Superintendent and subject to the Superintendent's approval, procedures for consistent compilation and reporting of all data necessary for the pilot project evaluation process and for compliance with the statistical reporting requirements set forth in 24-A M.R.S.A. § 2384-C, Bureau of Insurance Rule 460, and other rules, statutes, and orders of general applicability. Data to be collected and reported to the designated advisory organization shall include all information necessary to calculate appropriate assessments, surcharges, and experience rating factors. Cost information reported shall encompass the entire cost of the claim, including deductibles, copayments, and other costs not borne by the plan.

10. Termination of pilot project or change in participant base

A. Any employer, benefit provider, or service provider intending to nonrenew or otherwise terminate participation in an approved pilot project must give at least sixty days' notice to the Superintendent and all other employers, benefit providers, and service providers participating in the pilot project, and must submit a termination plan satisfactory to the Superintendent which provides an orderly mechanism to protect the rights of covered employees and dependents and other plan participants, including the rights to continuing payment of benefits for work-related conditions, and to fulfill all applicable obligations to participate in the evaluation process.

B. Termination of any self-insured component of a pilot project, including withdrawal by a participating employer from a participating self-insured group, must comply with the requirements of Bureau of Insurance Rule 250, except to the extent those requirements are expressly modified by the Superintendent for good cause shown, for reasons resulting from the unique features of the benefit plan and not impairing the rights of covered employees. The Superintendent shall establish a termination plan if for any reason a satisfactory termination plan is not submitted in a timely manner by the employer.

C. If an individual or group self-insurer that has been granted a modification of the standards of Bureau of Insurance Rule 250 pursuant to this Rule intends to continue self-insuring its Maine workers' compensation liabilities after terminating its pilot project participation, and the Superintendent finds that approval of the self-insurance plan is likely, the Superintendent may on a discretionary basis authorize a reasonable transition period, not to exceed sixty days, during which the employer may self-insure all or part of its workers' compensation benefits without full compliance with the requirements of Bureau of Insurance Rule 250, provided that the employer complies with the terms of a transition plan approved or established by the Superintendent. A transition plan may be renewed or modified by the Superintendent for good cause shown.

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D. If a benefit provider or service provider gives notice of intent to terminate participation in a pilot project, or terminates participation, its responsibilities may be assumed by a new benefit provider or service provider if the proposed participants in the restructured pilot project file a transition plan satisfactory to the Superintendent.

E. The Superintendent may revoke or decline to renew the approval of a pilot project, or an employer's right to participate in a multi-employer pilot project, on a showing that:

- i) the pilot project has failed to deliver the intended benefits to injured workers;
- ii) a participating employer, benefit provider, or service provider has dissolved, become insolvent, or has ceased to do business in the State of Maine;
- iii) a participating employer, benefit provider, or service provider has violated the terms of the plan approved by the Superintendent or with the provisions of this Rule or other applicable law;
- iv) there is a strong likelihood that a participating employer, benefit provider, or service provider will be unable to continue to fulfill its obligations under the terms of the plan;
- v) a benefit provider has demonstrated a valid ground for cancellation or nonrenewal of coverage; or
- vi) grounds exist for the revocation or suspension of authority of a participating benefit provider or service provider.

F. An order terminating a pilot project involuntarily shall include such terms and conditions as are necessary to protect the rights of covered employees and their dependents, and of pilot project participants that were not responsible for the events giving rise to the revocation. Where possible, the termination order shall also include appropriate terms to facilitate meaningful evaluation of the results of the pilot project.

G. Notice and opportunity for hearing must be given in advance of the effective date of any revocation or nonrenewal unless the Superintendent determines that exigent circumstances require an expedited termination. The Superintendent shall in such cases take all reasonable measures, including establishing appropriate grace periods and transition orders, to facilitate continuity of coverage.

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H. If 24-hour coverage plans are authorized on a permanent, non experimental basis, or if statutory authority for 24-hour coverage is terminated, the Superintendent shall issue a transition order establishing the terms for replacement or termination of all ongoing 24-hour coverage pilot projects.

11. Surcharges assessment and guaranty fund participation

A. Nothing in this Rule enlarges or diminishes the responsibility of benefit providers and participating employers to pay all applicable assessments and surcharges, which shall be calculated separately for each component benefit plan within a pilot project according to whether the plan is self-insured or insured and whether it provides workers' compensation coverage or non-occupational health coverage.

B. Any self-insured plan, other than a public employer plan exempt from guaranty fund participation pursuant to 39-A M.R.S.A. § 404(2), is covered by and subject to assessment for the Maine Self-Insurance Guarantee Association to the extent that it provides workers' compensation benefits. Any benefit plan underwritten by an authorized carrier not otherwise exempt from guaranty fund participation is covered by the workers' compensation account of the Maine Insurance Guaranty Association to the extent that it provides workers' compensation benefits, is covered by the health insurance account of the Maine Life and Health Insurance Guaranty Association to the extent that it does not provide workers' compensation benefits, and is subject to assessment accordingly. The obligation of any guaranty fund to pay a claim in the event of a benefit provider's insolvency is limited to the portion of the claim for which that benefit provider would have been responsible if it were solvent.

C. If some, but not all, of a participating employer's workers' compensation benefits are self-insured, the basis for applicable assessments and Fresh Start surcharges shall be calculated as follows:

- i) the employer's annual standard workers' compensation premium shall be calculated pursuant to 39-A M.R.S.A. § 404(4), and apportioned between indemnity and medical coverage in the proportions shown in the most recent approved loss cost filing by the designated workers' compensation advisory organization;
- ii) if the employer's workers' compensation indemnity liability or medical liability is partially insured and partially self-insured, the self-insured portion of the annual standard premium for that liability shall be calculated by subtracting the portion of the insured premium located to that liability from the full standard premium calculated in accordance with Subparagraph (i), but shall not be less than zero;

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- iii) the self-insurance portion of the employer's Fresh Start assessment shall be calculated with reference to the employer's entire prior year payroll or base year premium in the manner provided in Bureau of Insurance Rule 720, reduced in addition to any applicable reduction under Rule 720 by a factor equal to the percentage of workers' compensation benefits determined to be self-insured pursuant to Paragraph (i) or (ii) of this Subsection.
- iv) The plan may also provide that the aggregate workers' compensation benefits to be reported pursuant to 39-A M.R.S.A. § 404(A)(1), and used in calculating the Workers' Compensation Board Administrative Fund assessment, are to be calculated by applying the proration factor from Paragraph (iii) of this Subsection to total benefits paid. The election whether to prorate aggregate benefits in this manner, or to allocate specific claims between occupational and non-occupational payments, must be made in advance and not on a year-to-year basis.

D. If an employer's new member assessment for the Maine Self-Insurance Guarantee Association is reduced because only a part of its workers' compensation liabilities are self-insured, and the employer subsequently self-insures an additional portion of its workers' compensation liabilities, the employer shall be treated as a new member of the Association with respect to the newly self-insured portion of its workers' compensation liabilities.

E. If a single benefit plan, other than a self-insured plan, provides both workers' compensation benefits and other benefits, the benefit provider and claim administrator shall be responsible for apportioning the premium or other assessment base between workers' compensation and health coverage in an equitable manner subject to review by the Superintendent and consistent with the definition of standard workers' compensation premium, and for keeping adequate records to support the apportionment.

12. Rating and statistical reporting

A. All policies and contracts for coverage to be used by authorized carriers, and the rates to be charged participating employers, shall be filed with the Superintendent as part of the pilot project application. In reviewing a pilot project's rating or cost allocation plan, the Superintendent shall give due consideration to the public policies underlying the experience rating of workers' compensation plans, the community rating of certain health plans, and the competitive rating of workers' compensation insurance, in the context of the pilot project as a whole.

B. An authorized carrier's participation in an approved pilot project shall not by itself be considered participation in the individual or small group health plan market within the meaning 24-A M.R.S.A. §§ 2736-C or 2808-B.

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- C. Reserves for health coverage must be maintained consistent with Bureau of Insurance Rule 130, except to the extent those requirements are expressly modified by the Superintendent for good cause shown, for reasons resulting from the unique features of the benefit plan and not impairing the rights of covered employees.
- D. The claim administrator is responsible for compliance with all statistical reporting requirements relating to health coverage, and is also responsible for compliance with all statistical reporting requirements relating to workers' compensation coverage, unless the terms of the pilot project as approved by the Superintendent assign that responsibility to the carrier or self-insurer providing indemnity coverage.
- E. The Maine Employers' Mutual Insurance Company shall develop a workers' compensation insurance policy which provides primary coverage for indemnity benefits only, and shall make this "basic wraparound policy" available to any participating employer satisfying underwriting guidelines approved by the Superintendent. Rates, forms, and underwriting guidelines for the basic policy shall be filed with the Superintendent of Insurance within 120 days after the effective date of this Rule. The basic policy and its rating structure may include appropriate conditions and incentives to control potential indemnity exposure resulting from the structure or operation of the medical coverage plan. In addition, all workers' compensation carriers are encouraged to work with pilot projects to develop indemnity policies responsive to their particular needs, either on a wraparound basis or as a component of a coordinated plan.
- F. A proposal for a 24-hour pilot project must demonstrate a satisfactory plan for allocating claims experience capable of producing experience modification factors which are fair to both the participating and non-participating employers. The designated advisory organization which administers the uniform workers' compensation experience rating plan, in consultation with the Superintendent and subject to the Superintendent's approval, shall develop appropriate experience rating formulas and procedures for indemnity-only coverage and for any other policy design for which experience rating is determined to be appropriate and whose scope of coverage includes all or part of an employer's workers' compensation liabilities.

1. Adjudicatory proceedings

- A. the Superintendent may enforce compliance with this Rule, pursuant to 24-A M.R.S.A. § 12-A, by any person or entity authorized pursuant to this Rule to act as a participating employer, benefit provider, or service provider, or acting in such capacity in this State without authorization.
- B. Any person aggrieved by the application of this Rule, or of any plan or procedure approved by the Superintendent pursuant to this Rule, may request a hearing before the

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Superintendent pursuant to 24-A M.R.S.A. § 229, except as to matters within the jurisdiction of the Workers' Compensation Board or claim handling disputes of a nature ordinarily outside the jurisdiction of the Superintendent.

14. Effect of invalidation

If any provision of this Rule or its application to any person or circumstance is held invalid, the Superintendent shall determine whether the invalid provision or application is essential to the proper regulation of 24-hour coverage plans. If nonessential, the provision or application shall be severed and the remainder of the Rule shall continue in full force and effect. If the provision or application is determined to be essential, the Superintendent shall either conduct appropriate emergency rule-making or shall declare the Rule invalid in its entirety and terminate authority for all pilot projects.

15. Effective date

This rule is effective March 1, 1995.

EFFECTIVE DATE: March 1, 1995

AMENDMENT: July 28, 1996

EFFECTIVE DATE (ELECTRONIC CONVERSION): January 14, 1997

NON-SUBSTANTIVE CORRECTIONS: August 1, 1997 - missing "related" replaced in Section 4(D)(i); missing "benefit" inserted in last paragraph of Section 8(E).

Massachusetts

Chapter 152: Section 10C Collective bargaining agreements; binding obligations and procedures

Section 10C. (1) Any employer, and the recognized or certified and exclusive representative of its employees may agree by collective bargaining to establish certain binding obligations and procedures relating to workers' compensation; provided, however, that the scope of the agreement shall be limited to:

- (a) benefits supplemental to those provided in sections thirty-four, thirty-four A, thirty-five and thirty-six;
- (b) an alternative dispute resolution system which may include but is not limited to arbitration, mediation and conciliation;
- (c) the use of a limited list of providers for medical treatment;
- (d) the use of a limited list of impartial physicians;
- (e) the creation of a light duty, modified job or return to work program;
- (f) the adoption of twenty-four hour health care coverage plan;
- (g) the establishment of safety committees and safety procedures; and
- (h) the establishment of vocational rehabilitation or retraining programs.